TBI and Substance Abuse Webcast, June 19, 2003

>>JOHN CORRIGAN: Welcome to TBI and Substance Abuse, the second in a series of webcasts presented by the National Association of State Head Injury Administrators in association with MCHB, the Maternal and Child Health Bureau of the Health Resources and Services Administration and the U.S. Department of Health and Human Services. I'm Dr. John Corrigan, Director of the Ohio Valley Center for Brain Injury Prevention and Rehabilitation at Ohio State University. I'll be your moderator today and one of three presenters for this webcast. NASHIA's mission is to assist state government in promoting partnerships and building systems to meet the needs of individuals with brain injury and their families. As you may know, there are at least 5.3 million Americans living with a permanent disability because of traumaic brain injury.

As you will hear today, most of these individuals have special risks when it comes to alcohol and other drug use. This webcast will present a conceptual model for services addressing the needs of individuals who live with both brain injury and substance use disorders. Tuning in with you today are approximately 100 locations, some with one individual watching, others with rooms full. We welcome you all. Over the course of the next year, two additional webcasts will be presented. So please watch NASHIA's website for more information. Today we are broadcasting from Boston, Massachusetts and want to thank the Statewide Head Injury programs director Deborah Kayman, and our on-site director, Rebecca Ponsias, for their assistance. I offer a special welcome to Betty Hastings, Director of the Federal TBI program at MCHB and her staff at the TBI Technical Assistance Center. This webcast was made possible through MCHB's Partnership for Information and Communication Cooperative Agreement with NASHIA. There are a few housekeeping details we need to address before getting started.

Those of you watching today may pose questions at any time during the webcast. Simply type your question in the white message window on the right of your computer screen. Select "Questions for Speaker" from the drop-down menu and then hit "Send." Please include your state or organization in your message so we will know where you are tuning in from. We will have three designated question and answer periods but invite you to submit questions any time. Questions that do not get answered during this live webcast will be saved and posted to NASHIA's website. Our PowerPoint slides will appear in the central window and will advance automatically.

The slide changes are synchronized with the presentation. You do not need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider, which you can access by clicking on the loud speaker icon. Those of you who selected

accessibility features when you registered will see text captioning underneath the video window. This webcast will be archived on NASHIA's website and will be available for replay after June 30th.

Today's topic is TBI and Substance Abuse. Joining me are Dr. Frank Sparadeo, Chairman of the Rhode Island Governor's Permanent Advisory Commission on TBI and Robert Ferris, LSW, from the Statewide Head Injury Program from the Massachussetes Rehabilitation Commission. Together we'll attempt to address a wide spectrum of information on how things are and how they could be for people with brain injury. And now let me begin by talking about the scope of the problem of TBI and substance abuse. There are three associations between substance use and traumatic brain injury we need to address in order to fully comprehend its scope. The first is intoxication and occurrence of TBI. The second is history of substance abuse among persons who incur TBIs, whether or not they were intoxicated at the time of their injury. And third, substance abuse and negative outcomes, what happens after abuse occurs after the injury. First, in terms of intoxication and traumatic brain injury, in 1995 we did a review of the published literature, North American literature, over the previous ten years looking at what proportions of samples were intoxicated at the time of their injury and found that about a third to a half of individuals were reported as having a blood alcohol content greater than .10. There was very minimal data on other drug screens.

We did a follow-up study in our own site in which we looked at 350 or so consecutive persons admitted to our brain injury unit, with traumatic brain injury, and found that approximately 25 percent had blood alcohol contents greater than .10, and for those with drug screens another 12 percent, making a total of 32 percent, or about one-third who had either intoxication due to alcohol or other drugs at the time of their injury. The TBI model systems data, which is used for primarily research purposes, and is not perhaps the optimum way of screening for substance use, found that 29 percent of individuals in that sample have blood alcohol content greater than .10. And probably the best indication we have, at least for all persons hospitalized, not just those in rehab, but all persons hospitalized, comes from the Colorado TBI surveillance system and follow-up system. And they found about one in five individuals hospitalized over a two-year period were intoxicated due to alcohol at the time of their injury.

Thus, if we're talking about hospitalizations in general, probably our best guess is about one in five individuals have been drinking and are intoxicated at the time of their injury. Hard to say what additional proportion had been using other drugs. But we do know that marijuana, cocaine, and other drugs do lead to injury in the same ways that alcohol does. And when we look at a rehabilitation group, then, we would expect as much as one-third of those individuals to have been using at the time of their injury. And this is one of several places where we see a selection factor for rehabilitation populations,

that substance use is worse in that group.

The second association then is history of substance abuse among persons who incur TBI. Again, in our review of the literature back in 1995, we looked at articles, at least the few that existed, that had asked about prior histories of substance abuse in the subjects that they were assessing. And one of the more startling results of that was that approaching two-thirds of adolescents and adults in rehabilitation populations had indeed prior histories of substance abuse. The other thing we learned from that review was that how you look for substance abuse made a difference in terms of how much you found.

And in those settings where it wasn't inquired about systematically, they tended to find lower rates. But in places where there were systematic screening and attempts to diagnose prior substance use problems, those settings found higher rates.

The TBI Model Systems National Data Set was analyzed recently, and there we found about 40 percent, 43 percent of individuals had at least problem alcohol use. Another almost one-third had used illicit drugs, illegal drugs. And almost one-half had a history of either. So not quite the two-thirds we saw from our literature review, but still a very substantial proportion. There have been two additional studies, however, where systematic methods of identifying prior substance use disorders were used and the findings in those two were remarkably similar. One we conducted at Ohio State and another conducted by Chuck Bombardier and his colleagues at the University of Washington. In both cases, 55 to 60 percent of individuals showed at least problem alcohol use. Another third had been, had a history of other drug use or worse. And almost 60 percent or approximately 60 percent having a history of either. Thus, when we're talking about rehabilitation populations, adolescents and adults in rehab, to be expecting some 60 percent of those individuals to have prior histories of alcohol abuse or dependence would seem at this point to be a pretty good estimate. From our study, what we also identified was that about two-thirds of that 60 percent would have diagnosable substance abuse problems and one-third would have diagnosable substance dependence problems.

The third association I want to mention today is the negative outcomes as a result of traumatic brain injury. And, again, in the earlier review article, we looked at any effects that were reported in the literature, but at that time it was primarily early effects drawn from the hospital records or the media time post-hospital discharge. What was pretty consistent was for both persons intoxicated at the time of injury, as well as those with a prior history, and those two things are hard to separate in many studies, there were multiple early effects. Those that included greater mortality in the group, more likely to have intracerebral bleeds, greater likelihood of respiratory problems, greater agitation and duration in agitation as well as cognitive deficits.

In the few studies where both the prior history and intoxication were looked at, it seemed that those with the prior history were more likely to be experiencing the complications, although that is something we can't conclude definitively. Also in terms of the affect after injury, there are series of studies that have looked at indicators of both brain structure and function in individuals with traumatic brain injury and substance abuse.

The next slide there you see the graph of the event related of both potentials that were recorded by people in Australia, and I won't try to do their study justice, but they looked at individuals who had, who were identified as being heavy social drinkers, not necessarily substance dependent, persons who had been hospitalized, not necessarily received rehab, just hospitalized due to a traumatic brain injury and people who had both, and people who had neither one of those. From left to right you see the control group, the group that had neither. Those with alcohol problems, those with traumatic brain injury and those with both. They measured the P300 amplitude, to oversimplify is an indication with the speed which the brain can respond to novel stimuli.
And lower, as you might have guessed, is worse in this case.

Examining the graph quickly, what you see is that for persons who had either alcohol problems or had a traumatic brain injury, there was a significant difference between them and the control subjects, those who had neither.
And in looking at people who had both TBI and alcohol problems, it was again almost as much slower.

Mathematically, an additive effect, meaning if you put the two together it's worse than either alone.
In terms of longer term recovery, that is an issue for us.
Other pieces of information we can piece together about outcomes and substance abuse are perhaps more sketchy, but first there is a honeymoon immediately after the injury.
This is a phenomenon that Jeff and colleagues at Virginia Commonwealth University first identified that individuals they assessed who had traumatic brain injuries were heavier users of alcohol and other drugs before their injury, but in the immediate post-injury period there was a significant decline.
There was a honeymoon, so to speak.
However, what we, what is becoming clear is that in the period two to five years after injury, use is increasing and that honeymoon, the opportunity created by the honeymoon may be being squandered.
In addition to those who resume prior use, there is some 10 to 20%, it appears, who develop substance abuse problems for the first time after their injuries.
And finally, in terms of a series of studies now that have been done, we do know for those individuals using after their brain injury, they have worse employment outcomes, more likely to be living alone but isolated, greater criminal activity, and lower subjective well-being or life satisfaction.

Those associations are not necessarily causative, but we know that they co-occur.

So to recap, there are a few points we should emphasize, and I will just point out a couple within that.
If we have 50 to 60% of people, we are talking about 60 to 80% of folks in rehabilitation that we know are at risk for substance use problems.
And those figures are the basis of the emphasis that has been given and needs to continue to be given to secondary prevention of substance use problems after traumatic brain injury.
The other effect I want to reinforce is that the added effect of substance use and traumatic brain injury.

I think there's growing evidence one can expect the use of alcohol or other drugs to limit the recovery that will happen after traumatic brain injury.
That might be both in terms of spontaneous recovery of the brain, but certainly in terms of the rehabilitation outcomes that, and the functional independence that a person would attain.

Having covered those slides, I want to take a few minutes here to respond to questions and answers, to questions, I hope we have the answers, that you might have.
A question comes in about what percent of injuries are tied to alcoholism?
Well, I think if we talk about alcoholism as alcohol dependence, we would certainly expect that the, the vast majority of the individuals that I have been talking about in these few slides are abusing at least, if not dependent upon alcohol.
In our work when we have looked at the drug of choice of individuals we work with, alcohol is the primary drug in some 70% or so.
And that's pretty consistent, actually, across all substance use populations and holds up within traumatic brain injury as well.
Actually, among that group if you ask them what beverage they prefer, the preferred alcoholic beverage, the preferred is beer.
And if you have watched television, particularly a sporting event recently, you see what we are up against in terms of secondary prevention.

A question comes in, who are the if physiological way alcohol and drugs affect a brain immediately after injury?

I would like to be able to provide more research than we have right now about the immediate effects that alcohol can have on the brain.
What we suspect is that in the early recovery, one of the ways the brain heals is by the neurons that remain, and the connections that have lost and nerve cells that have died, the remaining make new connections in order for the brain to communicate optimally, and in the ways that it did prior to injury.
That process is called dendrytick prefusion.

It looks like a tree where the branches are spreading out.
One possibility on the research of alcohol effect on the brain, is that alcohol serves to inhibit that profusion, the ability of the remaining neurons, the spontaneous healing that occurs in the early period after the injury.

Another question that I often hear is who is the most vulnerable for developing substance use problems after traumatic brain injury?
As you might suspect, based on what we have talked about already today, individuals who had problems of use before their injury are clearly the first group you would include in a group at risk.
While it is certainly possible that an individual who has addressed substance use in their life and has sustained a recovery will also maintain that recovery after their injury, you would also, at the same time you would want to, to think of that person as greater risk than the person who had not had a substance use problem at all.
Of course the individual who was abusing or dependent on alcohol or other drugs at the time of their injury during the period when the injury occurred would be at significant risk, and really the only thing that may change that risk is if in the post-injury period there are actual barriers to their resuming their use, maybe they end up unfortunately in an institutional setting where they cannot get access to alcohol or other drugs, or back in their parents' home where supervision is closer and is prohibiting that use.
Or maybe their mobility limitations don't allow them to have the access they had before.
Unfortunately in our experience is that unless there are one of those barriers exists for the individual who is abusing substances before their injury, the likelihood that they will be abusing again in two to five years afterwards is quite high.

Another question here.
If someone in substance abuse treatment says they have a history of brain injury, is there any way, other than drug testing, to determine whether they are or still using drugs?
Well, I think the issue of how we detect substance use, how that works into treatment is actually going to be addressed more by my colleagues later in this webcast.
But while drug testing is certainly one option, it has to be used in a clinical context, particularly the context of the therapeutic relationship that the counselor or other individual is working with the person has established.
We rely a whole lot on self-report and feel pretty confident that when we have a trusting relationship, self-report is pretty accurate.
Another question is are there any ways to differentiate organic symptoms such as slurred speech from drug or alcohol effects?
There, that is, that is certainly more difficult.
There are, particularly in terms of slurred speech, there, we often see the innocent confusion of that issue when individuals are confronted by police

officers or others who are assuming that they're intoxicated when it is simply their slurred speech.
But as a professional, I'm not aware of any litmus test one can use.
Obviously other signs that a person is currently intoxicated would be there if it is the alcohol or other drugs that are causing the slurred speech or ataxia.

Why is there a honeymoon from using and why does it end?
I think this issue of the honeymoon is one that as a field we definitely need to be giving more attention to.
I think by the way, we see it both in terms of traumatic brain injury as well as injuries in general, individuals who have looked at alcohol use among trauma patients also see this honeymoon period.
Tends to be shorter, perhaps, in that group than we see in the rehabilitation population, but it's still there.
Obviously an injury, a traumatic brain injury is a significant consequence.
And to the extent that an individual sees any connection between their use and that brain injury, they may decide that that's something they want to avoid in the future.
As I have alluded to already, they may have different supervision after their injury.
They may be living somewhere different, they just may simply be more involved with professionals or others where their use might be monitored.
And of course there might be medical advice that they are receiving to caution about drug interactions or greater risk of seizure after their injury.
So there are multiple reasons why someone might reduce or eliminate their use immediately.
Why does it end, that's certainly more speculative, but the, what one's mind goes to first is just issues of coping.
If this was a way that one coped with life's situations before your injury, certainly there are multiple new things to cope with after your injury.
So whether it's out of frustration, out of boredom, or even low mood and depression, these are all reasons a person might begin to use substances again.
One additional that we see quite frequently and I think poses special problems are individuals who experience anxiety after the traumatic brain injury and one way or another find that the use of marijuana or alcohol helps them reduce their anxiety.
This is particularly an association and one that we find more difficult to, to separate, but indeed, can be addressed.

Of course in terms of why the honeymoon ends, another real possibility and something we see quite frequently is that if drinking or use of other drugs was part of a person's life before, there's a tremendous push, as we all know, to try to return to normal, to, to the extent that our activities after the injury are like the ones before, then we feel like the brain injury hasn't been so bad.

So if that means going out with the guys and drinking on Friday and Saturday nights, if that means using again down at the park, then those signals of returning to normalcy may be reasons why an individual resumes their use.

Questions come in, is there any relationship between pre-injury diagnoses, like attention deficit, hyperactivity, and the impact on the use of alcohol or drugs to self-medicate?
The question of self-medication is one that comes up frequently, and I think that maybe our other presenters will be discussing it more.
Clearly a, for some individuals they are using in attempt to self-medicate and amongst the individuals who have attention deficit, that's a dynamic that's reported in the literature more generally and would certainly be expected to be part of traumatic brain injury as well.
As I indicated earlier, clearly in terms of experiencing anxiety after injury, and sometimes that's hard to separate from the feelings of hyper excitement or hyperactivity, that there are definitely effects and attempts to self-medicate after the injury.

Question here, why do so many people with TBI have prior histories of substance abuse?
I think, I think there is a cycle of use leading to injuries, making bad decisions while you are intoxicated.
If we look at the three primary causes of traumatic brain injury, moving vehicle crashes, falls and assaults, all are associated to some degree to use at the time.
So leading the injury, and I think what we will see in time is an injury leading to use creates kind of a spiraling effect, and increases the odds considerably.
I think all of us who have worked with, in the field of substance abuse and traumatic brain injury have known many individuals who have had multiple injuries, multiple traumatic brain injuries.
Three, five, six, more.
Some of them may have been milder, and others more severe, but this cycle of using an injury, using and injury, is one that doesn't get broken easily.
How does heroin affect the brain, what specific brain injury is caused?
I think all, it's kind of beyond this webcast to talk about the neurochemical processes known and thoughts exist in terms of heroin use, but what we would say at this juncture is that however it is affecting the brain, a person with a traumatic brain injury has a more vulnerable brain, and as in so many other instances we are seeing an exaggeration of whatever effects are there.

The question is how does the rate of a history, prior history of substance abuse for persons without traumatic brain injury compare to those who have a traumatic brain injury?
And the -- there are a couple of ways to look at that rate, but we would say that it is no less than double and probably is higher than that.

I'm going to end our questions there and transition ourselves into the next section of this webcast.
And to do that, to kind of set the framework for our other presenters, I want to present a, the four quadrant model of service provision, to kind of give you a road map through the remainder of the webcast.
This model was borrowed heavily from co-occurring disorders, mental illness and substance abuse, for those of you who are in the substance abuse you may recognize.
Plotted along one axis there is the severity of the acquired brain injury, from low to high, and the other is low to high substance use disorder.
Where we are going to come into contact with individuals and have an opportunity to intervene is going to vary based on this, the accuity disorders.
It's going to be emergency departments, trauma services of hospitals, physician's offices or clinics.
However, when either disorder is more severe, the primary point of contact is likely to be in the treatment setting set up for those disorders.
If it's a more severe brain injury than quadrant two there, treatment in rehabilitation programs and services is the most likely contact point for additional services.
In quadrant three, substance abuse system, with the more severe substance use, less severe brain injury.
And four is about integrated treatment we would hope in the community for individuals with high severity of both disorders.
The next slide we have kind of further elaborated the kind of care that individuals might receive and that's what we will be talking about for the remainder of the webcast.
For the most part.
Unfortunately, for quadrant one, the screening, perhaps brief intervention, referral that might occur, is not something we'll be talking about today.
That may have to wait for another time, and just was more than we could fit in to the available minutes.

However, the collaborative care that will occur either in rehabilitation programs and services which Dr. Frank Sparadeo will be addressing, or addressed by Bob Ferris, will be discussed in the next two segments.
We will end today with all three of us sharing some thoughts on integrated programs, and special issues, as well as some of the components of what might be an ideal community-based model.
And with that, I'll turn it over to Frank Sparadeo who had been discussing quadrant two.

>>FRANK SPARADEO: Thank you very much.
Some 15 years ago there was a meeting at the annual conference of the brain association and at that time I was introduced to Dr. David Strauss who was talking about this issue, and I had been working in the area of clinical work for

five to ten years prior to that, and at that time a task force was formed that he headed up, and one of the first things that occurred was a survey that was done conducting, asking questions related to a number of services provided for substance abuse by various TBI agencies and hospitals, rehab hospitals throughout the country.

The initial findings were somewhat dismal in that a majority of facilities nationwide were not providing substance abuse services despite the numbers that Dr. Corrigan just reported to you.
After a couple of years of workshops and trainings and publications, we were happy to report in a follow-up study that a majority of TBI facilities now were reporting that they were at least addressing the issue.
As we stand today, most facilities, when you ask what type of services they provide for substance use disorders, there will be a great variety.
Some facilities will simply address the issue lightly by asking a few questions of the patient.
Others will have specific programs in place.
In my travels over the years I have been asked to assist in the development of substance use services, and there are two major issues that I feel are obviously critical to address when TBI programs are making judgments about the quality of their services regarding substance abuse.
Obviously clinical issues are the first.
That's our main mission is to treat our patients properly and appropriately and when the issue of substance abuse arises we should have the capability of dealing with that.
TBI survivors who are substance abusers either prior or post-injury have unique characteristics, they have different than TBI survivors not using substances.
It's been my experience that integrated treatment methods work the best, occupational therapists, social workers, psychologist, so on, there needs to be integrated in the overall clinical philosophy issues that address substance use in the TBI population.

Programs can have a clinical entity regarding substance use.
Don't have to have a formal program or policy.
I think the long run it is better if policies are developed and some semblance of programmatic approach.
Training is also an issue.
It must be sure that all members of the staff have the proper training and experience to go forward with the treatment process.
Some of the obvious clinical issues I wanted to just review have to do with a number of factors that most clinicians certainly will be familiar with.
When I have been called in to consult on an individual case basis the first place I look is the record.
Medical record.
Why do I look there?

It's a chronicle of what's been going on in the program since the client entered the program.
Often times it gives you a history of the substance use disorder.
Client may be progressing well and suddenly plateaus and progresses again and plateaus or regresses.
Usually indicators of something going on, usually substance use.
Often times the clinical treatment or ecology is important to consider.
Sometimes it stimulates substance use.
How do I mean that, I have had experiences where there's been heavy emphasis placed on socialization programs and people who have social anxiety and that creates cravings for reduction of the society, of alcohol and other substances.
There needs to be specific clinical questions generated on a regular base by the treatment team that relates to both recovery from the substances the client is using, as well as their TBI issues.

Team meetings, I think, are particularly important for all clients, but in this case substance abuse clients can be unpredictable, and therefore team meetings are very critical.
The client's expectations, what are his expectations regarding the treatment he will receive, whatever the expectations of that client regarding their future, and future use of that substance, and finally, when a substance use client has been identified, there needs to be an assessment and that needs to be shared with the client directly so that an appropriate treatment plan can be developed.
Continuing on with clinical issues, the treatment approach in my estimation needs to have a philosophical under pinning.
By that I mean when we decide we are going to actually have a treatment approach that's going to address substance abuse, the person who is going to lead that clinical approach needs to have an understanding of the dynamics of that substance use and how the specific method of treatment will affect that.

Family involvement is another critical factor.
Often times our clients are identified as users and we don't ask the proper questions of the family and turns out that sometimes that use is being reinforced by the family.
The role of self-help groups, I am an advocate of self-help groups but in some cases an individual's cognitive disabilities are so great, they cannot participate, that needs to be taken into account.
Sometimes modifications can be made.
A question was brought up earlier about drug and alcohol testing, a controversial question, in that there are people who are totally against that, and then other people at the other end of the spectrum.
Often times the use of drug testing is even requested by the client themselves to keep them honest throughout the process of treatment.
And I certainly have had a lot of experience using drug testing as a component of a treatment experience.

What does the TBI program recommend for after care?
That can be a complex question.
It depends quite a bit on the availability of services in the particular community.
Some communities having a greater integrated services, others not.
The programmatic issues are certainly, have to do with very basic policies.
What do we do as a treatment facility if a client comes into the facility under the influence of a substance, very important policy question.
What happens if the client is seen using substances on the facility ground, what is the policy going to be?
What will the policy be regarding substances used at an agency's event.

This may not seem to be something that is seen frequently, however it is.
Often times outpatient programs, as well as inpatient programs have social events that involve families and clients and staff and there may be alcohol served at those events.
If it is, what's going to be the policy regarding an act of a client using a substance at one of those events.
What if the staff is using substances at a social event or any other event and the client happens to see that?
And should drug testing include the staff as well as the clients?
Those are important policy questions.
I'm not going to answer those for you today but raise those as issues that will come up as you develop programming.
I have a particular interest in staff development.
I believe that the most effective way of treating substance abuse in the TBI environment is to make sure that all staff have a working knowledge of substance use and its impact on the rehabilitation process.
Staff knowledge can be assessed.
Dr. Allen Hienman wrote an article, and he has a survey instrument that can be used, to address what does the staff know about substance use, what are the attitudes towards substance use, and I think that's critical before initiating formal programming.

When I consult with an agency, I usually recommend that we certainly educate and train clinical staff, that's obvious.
But I also believe that support staff need to be educated, as well as administrative and leadership staff.
Let me give you one quick example why.
At one time I was actually operating a residential facility when a particular client, seemed to be intoxicated on a couple occasions.
Could not figure out where he was getting the stance.
The grounds keeper was giving him occasional nips of alcohol from time to time because he felt bad for the guy.

So that's why I say that the whole staff need to be educated, not just the clinical staff.
And the leadership staff should be participating in education and training because obviously their leadership and the clinical staff will look toward the leadership in terms of how they are going to continue their work in treating substance abuse.

The implementation of training programs takes time and the leadership needs to consider building into the education and training budget a number of sessions for training and substance abuse.
Additional programs I want to discuss have to do with making decisions regarding the specific assessment process.
There are formal instruments available for assessing substance abuse, and these instruments vary from facility to facility.
I use a particular set of them.
They are on this particular slide.
Substance abuse subtle screening inventory and the questionnaire, inventory of drinking situations, situational confidence questionnaire, many others that are available.
Interview techniques are critical.

Trying to discuss the issue of substance use in a client that it may be resistant or in denial, takes talent, it takes experience, and it takes training.
Psychosocial assessment is critical.
A cognitive influence, obviously if an individual is using substances and also has cognitive disability, the specific treatment methodology may need to be altered.
There needs to be programmatic procedures.
One of the things that stimulates substance use in an individual or group of individuals, needs to be procedures.
Often times, it's common to have as part of a substance abuse program having a trigger group where we sit and discuss amongst the clients their various triggers, and that each of the clients are able to coach one another in helping them either cope or avoid the triggers.
Understanding previous successes in the client could be part of the natural process of treating substance abuse, people who have succeeded in the past will have specific techniques that they use to help them do that, and it will be important as clinicians to make sure that is something that is part of the treatment program.
Development of treatment protocols, I think, is clearly a very important topic.
There are now various models of intervention, motivational enhancement therapy, cognitive behavior therapy, self-help models, integrated models, skills development models, many that can be employed.
What you will find in applying models to the substance abuse, to the TBI substance abuse population, often times they need to be changed or altered, depending on the particular cognitive deficit that may be present in the case.

I think it's very important that models be matched with the skill level of the staff, as well as the particular aspect, clinical aspects of the case load.
It would be very difficult to simply impose skills-based cognitive behavior therapy approach to, and ask that approach be applied by staff that are not trained in that approach.
So obviously there needs to be a matching.

What do your staff currently, what is their level of training right now, what do they need to learn, how does that match up with a specific programmatic approach or treatment.
I happen to be an advocate of developing a clinical leader in the TBI program who understands substance abuse issues to a greater degree than anyone else on the staff.
A person they can use as a resource, continue to educate and bring knowledge to the staff throughout the year.
I have been actively involved in developing and implementing staff development programs.
I use this three-component curriculum.
This was a curriculum developed as a result of work done at the statewide injury program in Massachusetts.
This is something that was actually implemented successfully throughout the state of Massachusetts and has been used nationally, in which we develop a particular curriculum that can be applied for training for clinical star, support staff, as well as administrative and leadership staff.
Once that program is initiated there can be follow-up attitude surveys to determine whether or not the staff training initiative was effective in making the staff ready to take on substance abuse cases full force.
At this point I would like to open it up to questions and answers.

>>JOHN CORRIGAN: Very good, Frank.
We are doing very well with our time.
So I think what we'll do is take a few questions.
There are many that have come in, and then we will be taking a break at 2:00, at the top of the hour for those of you have not in the eastern time zone.
First, a question from Arkansas.
How does AA fit into the overall treatment process?

>>FRANK SPARADEO: That's a very good question.
I think alcoholics anonymous, as well as narcotics anonymous and other self-help groups become very critical in the long-term care of the case, as well as the early phases of treatment.
Many patients that have traumatic brain injury are certainly capable and in fact thrive in the self-help approach and do quite well when introduced to alcoholics anonymous.
However, there is another group of TBI survivors that are cognitively challenged to a point they find it difficult during the AA approach.

The way I handle this and the way I have handled it in the past is I have incorporated AA groups in the program itself, and then attended those meetings or had clinical staff attend.

And then a follow-up group would be held in which information would be repeated and discussed to make sure that the, that the clients were actually getting an accurate picture of what went on during the meeting.
Many years ago there were 12 steps, were rewritten so that they could be more easily understood by individuals that might have cognitive disorders.
Those appeared in the national brain injury association white paperback in the late 1980s, and are still used by many people.
So I believe AA has a very critical role and I certainly as a clinician use AA quite frequently as a resource.

>> JOHN CORRIGAN: Patty from Virginia asks, any thoughts on the connection between injury, pain management, and addiction?

>>FRANK SPARADEO: That is a great question and will require a complex answer which I will only be able to address very briefly, unfortunately.
That happens to be a population that isn't discussed very often but a population I see quite frequently.
One of the issues obviously that occurs in this population is that there is sometimes a need for the prescription of narcotic medications and often times these clients will become severely addicted, to drugs like Oxycontin, headache pain, back pain, any other forms they are experiencing.
I did a research study probably ten years ago looking at the incidence of chronic pain in the TBI population, and surprisingly found somewhere around 45 to 50% of TBI survivors complaining of some type of spinal pain, either neck, upper back or lower back pain.
And that obviously becomes a major critical, clinical issue when there is an orthopedic surgeon or neurosurgeon involved and prescribing narcotic medication or anti-spasmodic medication such as Valium or any of the other types which are addictive medications.
Occasionally we will see a patient who has got themselves addicted to either alcohol or street drugs, heroin, for the purpose of treating their pain.
And these are not easy cases.
It requires the patient detox, number one, and number two, the patient has to learn pain management techniques.
Again, the same issues present that are learning to be sober are also present in learning to manage pain.
That requires a lot of good cognitive skills and you have to be able to adapt the intervention or whatever the particular cognitive deficiency might be.

>> JOHN CORRIGAN: You mentioned that there are some policy questions when thinking about drug testing within a setting.

What are some of the unique barriers that you have seen, and problems with implementation, when a study decides to go forward with some type of drug testing?

>>FRANK SPARADEO: The first objection to drug testing that I have seen usually comes from clients, and usually clients who are using, who will make the statement that it is an infringement upon their rights.
Of course that can be dealt with clinically.
The second issue that comes up is the staff complaining of the same issue, that this might in someway be some violation of privacy that drug testing be utilized.
It becomes a bigger issue when the program says that all individuals coming into the treatment process must undergo urine screening.
That becomes a much more controversial issue, and then the clients raise the issue, what about the staff.
You will either have cooperative staff or not.
Obviously the staff, I don't believe can be mandated to do drug testing.
But I have certainly been involved with situations when staff members have been tested to satisfy the client's request.
But I have used drug testing clinically quite frequently, and it's been very beneficial at times.

>> JOHN CORRIGAN: Patty from Virginia asked about preferred assessment tools which you have addressed to some degree, how about screening tools specifically?

>>FRANK SPARADEO: Well, I use a particular set of screening tools.
There are many out there.
One screening tool I didn't mention in the slide is the quantity frequency variability index, a very old measure, but does give you some idea of the person's history of substance use which certainly has implications for future use.
In terms of screening for current substance use, there is formal procedures and informal procedures.
Some of the formal I have listed on the slide.
The subtle screening inventory, the alcohol expectancy questionnaire quite a bit.
There is another method which is more behavioral in that if you are treating a TBI patient over time and you are looking at particular measures, like, for example, physical therapy measures, looking at range of motion and you are looking at the particular variables that the physical therapist feels are critical in the therapy, or occupational therapy, you will notice inconsistency about what is being reported by the therapist.
The patient may suddenly become weak when they have been on the progressive path getting stronger.

I have been involved with cases in which speech therapy is going quite well, the patient is improving dramatically and then suddenly they are using inappropriate words or having word finding difficulties they didn't have the previous week.
Those usually raise my suspicions, and then I begin to ask questions about substance use at that point.
The inventory of drinking situations is a pretty good measure.
Looking across the spectrum of possible circumstances a person might find themselves in and what the probability is they'll use alcohol at that time.
Some of the drug screening measures I have not used as much.
I use mostly the alcohol screening measures, and the subtle, substance abuse subtle screening inventory.

>> JOHN CORRIGAN: Follow-up question from Patty asking about adapting assessment tools.
I'm sure that would include screening tools, used when people have cognitive difficulties.

>>FRANK SPARADEO: That's a very good point.
And often times, depending on the severity of the cognitive disability, you may have to use these instruments perhaps differently than what, and differently from what the manual tells you.
I will sometimes sit with a patient and read the questions to the patient and see if they fully understand the questions.
Or I'll give the questions to the patient and I'll do a quick scan of the responses and go back in and pick certain items that I feel are critical and repeat those verbally to the patient.
That's the best way I find to get around that issue.

>> JOHN CORRIGAN: Question coming from San Francisco, would you suggest having a brain injury AA group?

>>FRANK SPARADEO: I think it's a great idea and I actually had a brain injury AA group for a couple years, both in an outpatient program that I was the neuro psychologist for and also a residential program and the AA group was held like any other AA group.
We contacted the AA central office, we had the, had information brochures and so on brought to us and we had an AA veteran, a member participate with us to create the meeting.
And it was pretty successful.
But it is highly dependent upon your availability clinically to be there as a coach during the process, and often times when budgets get tight, these are the kind of approaches that get eliminated.
I have seen these come and go over the years and I can tell you clinically they are very helpful and I would be very much an advocate for using these kinds of groups in TBI programs.

>> JOHN CORRIGAN: Here is a question kind of coming from the other end of the spectrum from Andy.
Can someone be involved in too many self-help, dual diagnosis groups where they become counter productive?

>> Yes, I think that that's a good question.
I think that there needs to be a treatment plan for all the clients that we see, and that overinvolvement in self-help groups, that is being a member of three or four different self-help groups may sound on the surface to be a great idea, but in fact, may actually result in some confusion.
Not all the groups have similar philosophies.
Certainly the NA and AA groups have the same basic 12-step philosophy.
However, you may find other self-help support groups that have differing philosophies.
That can become quite confusing.
And so I think you have to really strike a clinical balance as to how much stimulation can one person take.
If you follow the AA principles, that individual is going to go to 90 meetings in 90 days, to also go to another 90 meetings for a different self-help group may be just a little bit of overload.

>> JOHN CORRIGAN: I have a clarification here that is a question from Patty, or coming from a roomful of AD people.
It's not that she's had too much coffee this morning.
Here is a question from Karen.
You mentioned training materials for staff.
Do you have any that you recommend or perhaps if not, what kind of materials do you use when you do staff training?

>>FRANK SPARADEO: Well, I use standard materials that I get from the NIAA and NIDA training materials. National institute of drug abuse, national institute of alcoholism and alcohol abuse.
I use those materials, readily available and often times free.
I follow a particular curriculum that I suppose if you wrote me you could, I could give you a copy of that curriculum.
It is in the publication staff development and traumatic brain injury textbook that was edited by Chuck, that was about ten years ago that book came out, and there is a curriculum in that book that I follow when I do the staff training process.
But the materials that are available are very, very good.
And you can also consult with the brain injury association and they have some materials.
There is also a small booklet that Bob Carol and I put together many years ago that can be used not only for clients who have substance use disorders but used as a training tool with staff as well.

>>JOHN CORRIGAN: Frank, thank you very much.
We are now going to turn to Bob Ferris who will talk about quadrant three, services within the substance abuse system.
Bob.

>>BOB FERRIS: Thanks, John.
The statewide head injury program is an organization that provides supportive and rehabilitative services to residence of Massachusetts who have sustained traumatic brain injury.
We have been doing it since 1985.
Early on we discovered what seemed to be a disproportionate number of people with substance abuse and alcohol problems who had a traumatic brain injury, were not being successful in traditional substance abuse rehab models. Going through the revolving doors of treatment far more than other individuals were, and this is, hearing this from substance abuse professionals in the field and people we began to work with.

Because of that, about 12 years ago the statewide head injury program developed a task program to look at the problems of substance abuse among the head injured population and out of that came ideas and protocols both for programs that Frank spoke about, programs, rehabilitative programs trying to deal with abuse issues, and we found ourselves on the other end of the spectrum working with substance abuse treatment programs to try to get them to modify their approaches so they would be more successful working with people with head injuries.
And some of the things that came out of that we'll be seeing in the following slides.

I want to make a point that much of this was a very collaborative effort with the substance abuse treatment programs.
Looking at how they do their job and how we could help them modify it so they could work better with people with traumatic brain injury.
I think the most important thing that we saw was the need to identify cognitive functioning strengths and deficits of people coming in to substance abuse treatment, that can either be in an outpatient modality or residence treatment.
So it was really necessary to obtain neuropsychological testing or the very minimum, summaries of tests that would speak to the cognitive deficits and strengths of people coming into the programs.
The second point is you have that information, and then you want to try to impress upon the staff within a substance abuse treatment model to use the information, to ensure counseling and the interactions with individuals are done in a manner that would maximize that person's ability to understand and follow through on expectations.

A good example of that, you may have a person that after head injury, their ability to really remember and comprehend things that are put to them in written forms just doesn't work.
You can write things down a dozen times, they can't integrate that.
So what they really need is a lot of verbal reinforcement.

On the other end, probably for a larger degree of people, having a lot of things in writing doesn't work, or having things in writing for them, sorry, it's really important to have cue cards and putting things in writing and a good example what we used in a residential program is actually give the ten house rules on a small card the person can keep in their pocket so they can look at it from time to time and remember they are not supposed to spoke in-house or in the bathroom so they don't get kicked out of the program.
I think the other thing we find is that it's important to recognize that there's a high degree of denial of cognitive and even functional deficits among people with brain injuries.
The vast majority of people I have worked with over the years, they recognize and will accept some of the deficit they have, some of the problems they have, but they really can have very long-term denial about their cognitive programs, and that kind of goes hand-in-hand in substance abuse treatment with the denial around the substance abuse issues.
So I think you have to be aware of both of those areas of denial.
Working with cognitively impaired people, I think it's very important to identify concrete examples of the behaviors related to their substance abuse, and use those to assist the individual in recognizing the need for treatment.
A week doesn't go by when someone I have referred to a residential treatment program I get a call from a residential treatment program because they have been interviewing somebody coming through the door and when they are sitting down and talking to the person why do you want to be here, why are you seeking treatment, they'll say Bob Ferris sent me.

But if the person is given examples by the interviewer of problems or troubles they have gotten into while drinking, they can be able to self-recognize and take the steps necessary to buy into the program.
Another important parting is knowing the premorbid drug use patterns as well as the current patterns of use.
Spending some time talking with family members or the individuals to find out what were their drug use patterns prior to their brain injury and to see how they may have changed, or how they increased or decreased.
Quite frequently what we see in a lot of the people we work with or entering into the treatment is their common presentation is that well, they weren't an alcoholic, they weren't an addict, they weren't a substance abuser before their injury and nothing has changed.

Drinking at the same level, the social drug taking at a certain level, and it's important for the treating professional to recognize the same level of use now

after the head injury is having, maybe having a much more profound effect, and it's that person that needs to get the message across to the head injured individual as he enters into treatment.
As Frank alluded to, it's also very important to know current prescribed medications and the interactions that they may be having.
The vast majority of people that the statewide head injury program works with may be on several different types of medications, some that might be acceptable, others that aren't, and often times I have had to work with individuals, physicians, to get them to modify the medications they are on so they can get into a residential treatment program with an allowable medication that's not going to have any kind of side effects in the treatment they are going to see when they are in-house.

Probably one of the biggest things that we have seen, the biggest effect we see in a drug treatment program is the need to increase the opportunities for one to one counseling and support or use of small group sessions.
I, clear message I give to the treatment providers I work with is to really stay away from large groups.
People need more individualized attention, need more focus on their own issues, and help bringing them into group discussions.
Frank had alluded to the use of what we talked about with special like AA groups for people with brain injuries.
One of the things that I have also supported in a lot of the premiums -- programs we work with is have buddies attend AA meetings with a head injured person and that buddy has been trained or has some knowledge, if not of traumatic brain injury, at least of the deficits that the individual that they are kind of hooked up with, and so that when they go to the AA meeting, a really good model that envelopes, they go to the AA meeting with the buddy and go out for coffee and the buddy can say what do you think about what Mike had to say, he sounded like the identical twin of the brain injured person, he didn't get it at the moment, but if he has somebody processing the information with him the lights go on and that's a very effective tool.

As is mentioned earlier, what we find I think to be the best forms of therapy in treatment tend to be to adjust and utilize motivational enhancement, cognitive approaches, behavioral approaches, and skill-based approaches.
Dr. Sparadeo alluded to skill books and we use those a lot.
We think they have a big payoff.
Clearly one of the things to avoid in our experience, at least, within treatment settings have been confrontational or approaches to therapy that are heavy on the psycho therapeutic end of things.
Once again, you are dealing with individuals who most often are going to benefit from very concrete-based kind of approaches to treatment and therapy.

For most individuals, too, I feel we try to stress with programs it's important to encourage individuals to use some kind of journal or notebook and assist them in using it.

A lot of head injured folks will gladly have a notebook they can carry around but also have to be cued to use it during sessions and put down important points so they can be refreshed and a lot of times what we'll say is stress before the next group session or the next private counseling session, they go back and look at the notes so they come into the session kind of remembering where they left off last week or yesterday or late yesterday afternoon.
I think it's very important to educate counselors and AA sponsors in how to present the 12-step model to people with brain injuries.
Dr. Sparadeo had alluded to what's a TBI version of the 12 steps, and unfortunately I was trying to get the copyright status on that prior to this website, and I did get it clarified yesterday so we will be posting that to the website in the future.
And that's a version of the 12 steps for head injured people as well as a thing that's called a letter to an NA or AA sponsor that's just a three-page document that kind of lightly goes over some of the major issues of head injury and how an AA or NA sponsor might want to take those into consideration when working with a head injured person.

I want to speak just briefly now about specifically approaches in residential, in residential substance abuse treatment.
Once again, these are things we have worked out, worked through, with residential providers that statewide head injury program has contracted with over the years, so we kind of know these work and we are still working on them.
The one thing is brain injury training for all the staff, for a lot of residential programs rely on sort of part-time counselors, people who have come through the house or the program, and are peer counselors for people.
I also include those when we provide training for the staff.
Ongoing consultation between the brain injury specialist and an identified staff.
I try to identify one key staff person in a residential program or an outpatient treatment facility who has pretty much, you know, easy access to me or one of our clinical consultants when questions or issues arise.

Acquisition of neuropsychological evaluations and/or comprehensive functional assessment of an incoming prior to the interview.
One of the things we do to all consumers, we get them to sign off on a release of information, that allows me to equip the residential program about the person as they are coming through the door.
I think it's very important and how many times people end up at the interview and in most cases historically from a residential treatment perspective, what they are looking at the interview is your reasons for being there.

And in the case of working with head injured people, what they are going to say when they get them there that I sent them there or the doctor said they need to be there, however if the professional interviewing them has history on them, they can have a better understanding and buy into the need for being into treatment and get off on the right foot.
Once again, the intake interview focusing on educating, so right from the get-go the reason they are there and what the program will do for them.
And higher levels of one to one counseling and/or small group sessions.
Several of the residential programs we work with receive one to one counseling on a daily basis as opposed to a weekly model that usually exists in those systems.

We also support the use of a mentoring or buddy system within a residential treatment program, and once again, training that buddy or training that individual on just some of the real basics of brain injury and cognitive deficits.
One of the things I think that are crucial in a residential treatment model is that the program rules and procedures need to be presented in a manner that the person understands them and can retain them.
Many of the people that, many of the consumers that get referred to residential treatment is not unlikely for the house rules to be posted in large print on the door of their room, and to be posted throughout the house or the program so that they can be reinforced every time they are moving through those, and often in some of the smaller programs, other members, other people that are there for treatment are also there as kind of living cues for people within the program.
I also think that approaches and methods of treatment may need to be modified in a manner that can be understood and retained by the individual.
One of the things that I have stressed in working with residential treatment programs is we are not looking to them to modify how they do treatment, how they are treating the substance abuse problem is not going to be drastically modified.

What they need to modify is how they approach that with the head injured person and how the head injured person is going to best learn and retain the information through those treatment sessions.
Probably the two most important things that also come out of residential treatment is that the length of stay is somewhat determined by the need of the consumer.
Many residential programs have very fixed dates as far as that goes.
Some of them are mandated by their funding sources, some might be three months in duration.
We have tried to get programs to understand that a person if he needs six months in the program, that's what's going to be successful.
And in most of the programs we have worked with we have seen the greatest long-term success with people who have remained in residential treatment for six months to a year.

And the other point is ongoing communications between the TBI specialist and the designated point person in the program.
The program they work with, they have my phone number, they can call me at any time.
When they have problems or issues with a consumer in the program.
And that's pretty much, I think it.
We'll go to questions and answers.

>>JOHN CORRIGAN: Yes, and there are a number.
Thank you, Bob.
First, this question comes from Gia Scott.
What is the ratio of the inpatient drug and alcohol people and how does that change with traumatic brain injury and how does that change with collaboration?

>>BOB FERRIS: Okay.
As I said in the beginning, what we found early on was that in talking with substance abuse professionals in residential models, that head injured people were coming through there, were basically going through their programs again and again and again.
So we could say that from that experience, that a majority of head injured people were not being at all successful in the treatment models that existed.
That they were resurfacing all the time.
As we have collaborated with programs, what we have seen, we now have a very high success rate in the programs we have worked directly with, over the past eight, almost nine years now, we have seen a 60 to 75% success rate, so also we have turned around from one in four people being successful to three and four being successful, and once again because the statewide head injury program has a long-term involvement with people we can track people for a long time.
We know it's not just conjecture.

>>JOHN CORRIGAN: Two questions coming in from colleagues in San Francisco.
When someone presents to a substance abuse program, what diagnostics can be used if it's not self, and what about the masking of symptoms of brain injury and substance abuse?

>>BOB FERRIS: I'm not, I'm not aware, and maybe Dr. Sparadeo could jump in there, I'm not aware of any real evaluations, per se, that you could do at the time of screening coming into a program or identifying, you know, or coming into a program and looking to work with them.
As I said earlier, I think it's vitally important for programs before they begin working with people, if, to get their hands on neuropsychological evaluations or other kind of cognitive screening tools so that they can identify and then basically work with the individual to kind of, you know, get them to buy into or agree that they have that problem.

One of the most significant problems and people are well aware of this in the head injury, rehabilitation community, is that the vast majority of people with head injuries can come into any programs, come into any venue, and don't have any clear indications that there's anything wrong with them, that they have any deficits.

>>FRANK SPARADEO: I might just add that our colleagues at the rehabilitation research and training center at Mount Sinai have developed a tool for assessing brain injury and we have been working on one as well, and we have found that there are indeed differences even in the cognitive presentation with folks with severe substance use disorders and traumatic brain injury and those with just severe substance use disorders.
That's an area we need to be doing more research on for sure.

>>BOB FERRIS: May I make one comment?
Interestingly over the years when I have interviewed individuals who are, have a substance abuse primary diagnosis, if I ask them whether they have had a brain injury they often will say no.
However, I ask them if they have ever been unconscious as well as of being hit on the head or whatever, they say yes, all the time.
So sometimes the terminology has to be right for them to answer properly.
Being knocked out to some people does not constitute a brain injury to them.
However, we know different.

>>JOHN CORRIGAN: Here is an interesting question.
When you refer to small groups, what size do you have in mind?
This comes from San Francisco.
What's small?

>>BOB FERRIS: I think at least the work I have done with both some outpatient clinics and with our residential providers is that a group of, you know, not to exceed six or eight people really seems to be, you know, ideally if it's two or three people, but I think getting beyond, you know, eight or ten people the issues really get lost for the head injured consumer.

>>JOHN CORRIGAN: This comes from Virginia.
Could you discuss relapse prevention efforts with persons with traumatic brain injury?

>>BOB FERRIS: One of the -- I think one of the major modifications that we have worked with and done with particularly residential providers, but also outpatient providers is that in a very kind of hard-fisted model of treatment sometimes there is a real closed door to immediate involvement in a program.
In other words, somebody graduates from a residential treatment program, and if they happen to relapse, they are not going to be able to get back into that program for six months, sometimes a year.

And I think one of the things we have tried to engineer -- put into a lot of programs is the reasons for relapse and let that drive what steps you talk.
Often for a lot of people with brain injuries what we have seen is that relapse, what they are looking at relapse is, is that they have had a slip, they have taken a drink impulsively, if you sat down and talked with them, you know, right after the fact, you would see the remorse.
You would see the recognition of the problem.
And not so much focus on it as we kind of traditionally see as a full blown relapse and to really tell people that taking one drink, having a slip is not a relapse, okay.
But the important part is to seek out treatment.

>>JOHN CORRIGAN: Here is a great question from Alabama.
How is the need for prescribed medication, the need for prescribed medication dealt with in residential settings?

>>BOB FERRIS: Most of the residential, most residential treatment programs that I'm aware of deal with people who do have medical, they have other medical needs, so they often have a locked and secure method for holding onto prescribed medications.
And in most cases the biggest problem is for often in programs what I hear is the person is, the individual is expected to know when they take their medications.
A modification in a head injured person where memory is severe pli impaired is that he can't be expected to do that.
We adapt the program to say you need to remind him to come down to the med cabinet at the time to get medications.
As I said earlier, there are certainly certain medications that no residential treatment program would want to see in-house.
And I think when we come across those, what I said earlier is we try to work with a prescribing physician, psychiatrist, whoever, to try to look for alternative medications that would be acceptable to the residential treatment program.

>>JOHN CORRIGAN: Two questions here about adapting treatment from residential into non-residential settings.
First, from Katie in New Jersey, how can these approaches be used in day treatment programs?

>>BOB FERRIS: Good question.
I think as I said, we have seen treatment, treatment being modified in an outpatient setting, either in small groups or for one to one counseling centers, and taking those modifications as we have talked about earlier.
And I think to some degree if what you're asking and it had more to do I think with what doctor Sparadeo was saying is that when you have day treatment programs that deal with issues other than substance abuse, it's once again back

to that more integrated model where you are providing both things in both settings on a consistent basis.

>>JOHN CORRIGAN: The follow-up related is how is the buddy system set up and sustained after discharge for ongoing support in the community, or can it be?

>>BOB FERRIS: Yeah.
I think once again, most of the programs we work with still rely heavily on AA and NA as after care supports.
So what you are talking about there is the individual sponsor, and so really the sponsor is the person that becomes the buddy, and as I said earlier and hopefully we will get it posted to the website later, there is actually a great letter to an NA or AA sponsor that kind of goes through some very simple steps that they may want to consider if they have that kind of appointment or relationship with somebody after treatment.

>>JOHN CORRIGAN: A question from Anna.
Is there a difference in recovery from patients who are substance abusers but those with other -- Difference for those with substance abuse, without substance abuse, the traumatic brain injury versus those with traumatic brain injury and substance abuse.

>>BOB FERRIS: I think, and this is what, hopefully I'm getting this right, we have actually when we, when I or our clinical team at the statewide head injury program might review an individual who is having problems related to substance use, what we clearly try to identify is, in fact, is this person an alcoholic or an addict and does their history speak to it, or is it, is the problem that the individual is maintaining his level of, like, social drinking or occasional drug use now after injury and having problems.

And I think that's what, that's where the focus really needs to be, and actually it was Dr. Sparadeo when he first started working with us that made that very clear to a lot of our programs, because it's very difficult for an individual to enter into, let's say, a residential treatment program and hear day after day that he's an addict or he's an alcoholic, when what he knows is he wasn't an addict or alcoholic before his head injury, okay.

But that his current, that same use of alcohol and other drugs are creating problems similar to those as we see in an alcoholic or an addict.

>>JOHN CORRIGAN: We have time I think for at least one more question, maybe a second.
This is a good one, again from Virginia.
Any comments on helping family members or caregivers setting limits with active substance abusing TBI clients?

>>BOB FERRIS: God bless you for trying is part of it.
I think this is one of the most difficult arenas for people to enter into.
I think it is a case where they can't make exceptions, you know, we're talking about, I have talked about for a while now making exceptions and changing models of treatment for substance abuse when working with a head injured person.
I think it's very important for families to kind of look and hold the line around substance abuse, the use of substances, the same as they would with a non-head injured person.
I think one of the troubling things we often see, we have come across it time and time again, is actually the use of like alcohol or the use of marijuana and the allowance of those things as a reward or at least, I don't know how many times I have heard a family member say look at, what else does he have to live for, a couple beers on a Friday?

You know, so it's this attitude, and reinforced by police.
I have yet to find very many head injured people that get arrested for even being very abusive in public when they are intoxicated.
They are kind of written off as well, you know, take pity on the individual.
So I think it's the opposite approach needs to be taken as far as you don't want to bend the rules, you don't want to change anything in trying to address use and abuse in a head injured person.

>>JOHN CORRIGAN: One last question for you.
In the experience, what are the two most important components in residential treatment that have led to long-term success for individuals with brain injuries?

>>BOB FERRIS: As I said earlier, I think what we have seen to be the most profound is length of treatment.
Most residential treatment programs go about three months, you know, three months and you are out, maybe six months.
What we have seen very dramatically is that if I can get an individual to stay in residential treatment for up to, for six months, up to a year, I don't see that person back in treatment for, you know, now seven, eight years out.
The people who have dropped out of treatment under six months who so have maybe been in the more traditional model show up back on our doorstep repeatedly.
So the most important part is the length of treatment.
The second most important part is, once again, as much of an integrated model as you can develop within treatment makes for the most success.
The best program I work with has, the best residential program I work with has a really wonderful integrated component, the director happens to be not only a former alcoholic and addict, but she had a traumatic brain injury, okay.
It was very easy for her to buy into an integrated treatment model because she lived through those things, and so I think once again, that's the other big part.

>>JOHN CORRIGAN: That's a wonderful segue into our final component of the webcast which is talk about the fourth quadrant, integrated treatment in the community, and all three of us will be sharing some of our ideas here.
We wish, I think, that these were more than ideas taken from just a few programs, but could be synthesized from many, many programs.
As we all know, there are not a lot of options for integrated treatment, and particularly community-based treatment.
We want to share with you a model that hopefully is on your screen right now, that describes some of what we think are the key components.
This is the whole picture.
And a few slides here we'll be looking at each of the components separately and talking about some of the challenges that are a special issue for persons with traumatic brain injury and substance abuse.
If I could have the next slide.
The therapeutic alliance is at the core of the model.

I think most of us have a pretty good idea of what that is, but just to, to summarize, therapeutic alliance is what exists in any helping relationship that is going well, I guess you would say, that it is the shared expectation between the help giver and the client that indeed there will be benefit from this involvement.
It's mutual agreement on both the treatment goals as well as the treatment process, and that's an important issue.
What are we going to do together to get to the goal.
And finally, it almost always includes shared feelings of trust and warmth.
However, there are unique challenges for persons with traumatic brain injury and traumatic brain injury and substance abuse, and most important I think in our experience as we have discussed is that it is more difficult for individuals who as a result of their brain injury may have frontal lobe problems and some of the things that go along with this, to establish these therapeutic alliances.
We were talking before the webcast about individuals who are not able to have empathy and read other people's feelings have more difficulty with life in general and more difficulty in establishing therapeutic relationships and alliances with any of the help givers they may be entering into treatment with.

>>FRANK SPARADEO: I often notice that this connection, what I called a disconnection from intellect and behavior, the individual may be able to say to me all the reasons why it's important to stay sober, why it's important not to smoke marijuana, but on the way home grab a drink.
I have sometimes been on the phone with these clients, telling me all the reasons why they don't want to drink and they'll be drinking on the phone.
There seems to be some kind of a situation in which intellect is not guiding the behavior, and I think that is probably due to some frontal lobe disconnection problems, and we as clinicians have to find the bridge.
How do we find that as a guiding device.

That's the challenge of the therapy and the interventions.
I think that's not an easy task and it requires a lot of differing cueing methods to do it.
Some of them may be very behavioral and concrete, and others may be more traditional, but I think there has to be a pretty wide range of approaches to try to solve that particular problem.

>>BOB FERRIS: And I also think as someone was asking about how you involve families, and once again, you had said this earlier, that's also sometimes the most difficult but also the crucial one, that the family is carrying over the same modalities, that they are using similar cues or if a person is using something or relying heavily on written cues, that they are cueing them to use those same tools and sort of staying on the same page as the treatment teams.

>>FRANK SPARADEO: I had an interesting experience with a case a few years back, the individual's family was very, very much in favor of the treatment we were doing, and that we were very happy about that.
We had created a pretty good treatment plan, but the individual wasn't changing at all.
What we found out is that the individual's father was asking this TBI client to go buy his beer for him.
And then expecting him not to drink it?
So the family didn't quite get it.
You are providing triggers and cues for your son that are tripping him into drinking.
We have to change the dynamic.
The only reason that came up is we asked, the client complained about the father making him do too many things and that was one on the list.
Our ears perked up and we noticed, this is the reason, one of the reasons why we are having trouble getting him to stay sober.

>>JOHN CORRIGAN: As we note on the slide, the professionals who work with folks who have the unique issues, obviously not everyone with TBI has these issues, but for those who do, it takes greater commitment by the professional to the relationship and greater flexibility in terms of engaging them.
We have suggested some programmatic options or system change issues that might need to be thought about if that's successful.
Looking at the next slide then, because in this fourth quadrant we have individuals who have both severe substance abuse and severe traumatic brain injury issues, there is going to be more than one therapeutic alliance, hopefully.
Multiple alliances.
And multiple bring their own additional special issue.
There are, the unique challenges include being the inconsistency that can come from multiple providers, sometimes not even saying different things,

sometimes being interpreted as saying different things, and if not inconsistent, at least confusion.

>>FRANK SPARADEO: I think this is a very important issue, particularly when TBI survivors are receiving multiple levels of care.
The example that comes to mind right away is a case in which an individual is giving normal physical therapy four, five times a week, in the course of the therapy made an offhanded comment about an up coming concert and the last time he went to this particular concert he smoked a significant amount of marijuana and he thought he would probably do the same thing at the next concert.
The concert was, in essence, a trigger for the use.
The therapist brought the issue to the team and that was a good issue to bring, because then we were able to sit down with him and plan a better approach to that concert.
I think this is why we talk about educating and giving knowledge to the entire team because clients will often, you know, this particular client had a very strong therapeutic alliance with the physical therapist, and she wasn't a counselor, wasn't a psychologist, she was a physical therapist but brought information to the team that would allowed a significant problem that night.

In our experience, there's a lot of benefit that occurs from working as a team.
We do it in inpatient residential settings, and sometimes neglect it in outpatient where the stimuli are more confusing.
Communicating amongst ourselves is key to that and once again a systems issue, not all agencies are open to giving staff the time and the flexibility to be part of the ad hoc teams of community-based service providers.
The next level of the model adds in those components of substance abuse treatment and rehabilitation to improve functional abilities.
The two critical components here that we have discussed is that first, that this treatment be simultaneous, not sequential.
Too often we have heard good get your substance abuse problem fixed and then come back and be in our rehab.
That is not optimal treatment, nor would be the reverse.
The second is that the treatment be integrated, not just parallel, not just going on at the same time, but that indeed it be integrated.
And some of the challenges to that occur both in terms of the substance abuse system which we might talk about first, and that's just the issue of cognitive and attitude accessibility.
We talk about physical accessibility, but attitude and cognitive accessibility in the existing substance abuse treatment system.
I think you talked a bit about that earlier, Bob.
And you have talked enough about that.

>>BOB FERRIS: I think, no, I think it's -- I think that is changing, but I think the

impetus, at least here in Massachusetts, the impetus for change did deal with a wider spectrum of disability awareness.
About eight years ago the department of public health here in Massachusetts bureau of substance abuse services had a year-long kind of task force working on the very issue of disability and substance abuse treatment.
So looking at all aspects from a perspective of physical access to treatment, both outpatient and residential, but also throwing in our sitting on that and looking at both, not only head injured people and their cognitive deficits, but also those of individuals with developmental, and retardation.
One of the things I do when I do presentations, even though I am there and speaking for traumatic brain injury people, and approaches we have helped develop, what I really try to focus it on is cognitive deficits and cognitive issues and reaching, that reaches out to a larger audience they may be serving because they may have in the populations the substance abuse programs and people with mental retardation, with other types of cognitive disabilities.
And then you see more lights go off and then a more collaborative he have fourth.
Oh, well, just can't help us with one person that we know has a head injury, but another, a whole segment of their population that has cognitive difficulties.

>>JOHN CORRIGAN: I think one, what's going on here in Massachusetts is really quite great from that perspective, and my frustration is in other places in that substance abuse facilities are not implementing cognitive assessments because they don't feel like they can do that, and I don't know if I want to learn it because it's another complex problem they have to solve.
So part of the training I think has to do with allowing people to realize they have skills in that area and that there are techniques that do not require them to be neuro psychologists, for example, but require them to do simple screening and if they can program those techniques they'll begin to integrate them.

>>FRANK SPARADEO: I might add, too.
Another thing we find, often because you have people in the programs that are not skilled or knowledgeable in the area, what we do is take an evaluation and have one of the clinicians, a 12-page evaluation into a two-page cheat sheet that is given to the counselor so they know the things up front.

>>JOHN CORRIGAN: It's not just the substance abuse providers who may have attitudinal barriers.
As indicated on the next slide, there is a bias view of substance abuse because it goes in both directions, it's a stereotype.
Because often the impression with people with substance abuse problems are not trustworthy or good or nice people, that in some settings the therapist may say this guy is nice so his substance abuse problem may not be that bad and overlook it, or the other they say he is a substance abuser.

I will move in the final component, wrapping case management around these services the purpose of case management is two-fold, to change the environment and organize the team.
And as we said, is that all?
And in many ways the case manager probably has the largest job of all of the providers involved, and thus some of the special accommodations like smaller case loads, structure and treatment, having case management in the first place to wrap around it.
If we ignore the other issues in a person's life, if we don't organize ourselves as a team we won't be as effective.
There is the full model again.
We are going to put up a final slide there with some suggestions that kind of grew out of all of our thinking about ways to make services more responsive.
Some of these are things that can be done when programs are simply collaborating, some of these are things done as part of integrated treatment.

I see that it's at the top of the hour, and we would like to thank you for being part of this program, and an on-line evaluation form will automatically appear at the end of the broadcast.
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I would like to thank the presenters, Frank and Bob, for an informative session, and of course Betty Hastings and the Maternal and Child Health Bureau for making this webcast possible.
We thank our audience and hope you join us for future webcasts.
I'm John Corrigan, thank you for participating.